STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Robert S. Baska , M.D.	)	Docket Nos. MPS-38-0501
	)	MPS-39-0501

HEARING COMMITTEE: Elizabeth A. Turner, M.D., J.D., Committee Chair
Katherine M. Ready, Public Member

PRESIDING OFFICER: Phillip J. Cykon, Esq.

APPEARANCES: James S. Arisman, Esq., Assistant Attorney General, for Petitioner
Leighton C. Detora, Esq., for Respondent
Robert S. Baska, M.D., Respondent

HEARING COMMITTEE REPORT

INTRODUCTION

This matter came before a Hearing Committee (Committee) of the Board of Medical Practice (Board) for disciplinary hearing on an Amended Specification of Charges issued by the Board on February 6, 2002. Hearings were held in Montpelier, Vermont on April 8, 9, 10, 11, 16, 17, 30 and May 1, 2, 3, 7, 8, 9, 13, and 14, 2002. The Committee has heard extensive evidence and has received extensive proposed findings and conclusions from both parties. While the Committee reviewed the proposals from the parties, the Committee did a significant amount of independent work reviewing the evidence offered and admitted at the hearing. Based upon the evidence, the Committee hereby reports its findings of fact and conclusions of law to the Board pursuant to 26 V.S.A. §1355(b).

Pursuant to 3 V.S.A. § 811, this Committee Report shall constitute a proposal for decision. It has also been served upon the parties to this matter, and each party adversely affected has the opportunity to file exceptions and present briefs and oral argument to the Board, who shall issue the final decision and order. The parties shall file their material and request oral argument within 10 days of the date of this Report. The parties may, by written stipulation, waive this opportunity and proceed directly to the determination of what sanction will be imposed.

FINDINGS OF FACT

GENERAL FINDINGS

1. Respondent, Robert S. Baska, M.D., is physician licensed by the Board. He holds Vermont Medical License Number 042-0008460, issued on February 5, 1992. Respondent is a general surgeon who formerly held privileges at Copley Hospital in Morrisville, Vermont. Respondent's license is currently suspended by action of the Board.

2. Under the Medical Practice Act, the Board does not license physicians by practice specialty. Instead, physicians licensed by the Board may designate their medical specialties themselves.

3. Respondent completed an internship and a surgical residency in the U.S. Army. He spent nine years on active duty and 4 years in the reserves of the U.S. Army. He left the Army in 1992.

4. Respondent is board certified as a general surgeon. He was a self-employed, solo practitioner in Morrisville. His office was at Copley Hospital, but he was not an employee of the hospital.

5. The Board opened two complaints against Respondent in May 2001. After a preliminary investigation, on August 9, 2001, the State filed a Motion for Summary Suspension of Respondent's license to practice medicine. On August 10, 2001, Respondent and the State entered into a Stipulation and Consent Order in which Respondent agreed to the summary suspension of his license.

6. Subsequently, Respondent filed a Motion to Lift Summary Suspension dated November 7, 2001. The Attorney General's Office filed a response in opposition dated November 30, 2001. By Decision and Entry dated December 9, 2001, the Board denied Respondent's Motion.

7. During the 15 days of hearing, the Committee heard extensive testimony by both fact witnesses and expert witnesses and examined numerous exhibits offered by both the State and the Respondent. The Committee listened carefully and was afforded the opportunity to ask questions of the witnesses, including the Respondent.

8. The burden of proof in disciplinary hearings before a licensing board such as this is a preponderance of the evidence.

9. The weight and credibility given to the witnesses, both lay and expert, is solely for the trier of fact, which in this case is the Committee.

COUNT 1. (PATIENT A)

10. This Count alleges unprofessional conduct under 26 V.S.A. § 1354(22) and 3 V.S.A. § 129a(a)(10), during Respondent's care of Patient A. The pertinent subsections of the statutes define "unprofessional conduct" to include a failure to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

11. Patient A was a female patient who had Crohn's disease, a chronic inflammatory disease of the gastrointestinal tract, which required continuing medical care and repeated hospital admissions. Respondent had provided surgical and other medical care for Patient A

for a period of years. Respondent began to provide care to Patient A in 1993. His medical care to her continued thereafter, as did the physician-patient relationship between them, from 1993 until March 2001.

12. In March 2001, Respondent performed a repeat resection of the ileo-colic anastomotic site (small bowel) in Patient A because of persistent abdominal pain and failure to respond to medical treatment which necessitated use of increasing doses of narcotic medications. Respondent had previously performed an endoscopy which he interpreted to show that the "internal ileum was markedly inflamed ..., there were numerous ulcers and mucous pockets [and] the colonic portion was normal". In addition, Respondent had ordered a "small bowel follow-through", an x-ray test used to visualize the small bowel, which includes the ileum. The interpretation of that test, done by the radiologist, was that it was "negative" or showed a normal small bowel.

13. On March 6, 2001, Respondent performed an exploratory laparotomy, adhesiolysis, terminal ileal resection and an ileocolic reanastomosis. Estimated blood loss during surgery was documented as "minimal to 100 cc's". Patient A's pre-operative hemoglobin and hematocrit were 14.9 and 45. On March 7, post-operative day 1, they were 8.5 and 27, indicating a significant loss of blood. The blood loss was estimated by one expert witness to be 1600 cc, of which 1500 cc was unaccounted for. The hemoglobin and hematocrit remained critically low and she required a transfusion of two units of packed red blood cells. Essentially, Patient A lost approximately half her blood volume during this period of time.

14. Post-operatively Patient A failed to do well clinically. She had a distended abdomen, prolonged ileus, occasional fever spikes, tenderness, pain, and a persistently elevated white blood count with a significant bandemia (50 and 60% bands on 2 occasions). Despite these significant indications of infection, Respondent failed to investigate the possibility that Patient A might be suffering an abdominal infection related to the surgery he had performed. Respondent did not respond with diagnostic steps, such as a CT scan, to determine whether there was infection at the surgical site.

15. Patient A also developed right lower lobe pneumonia, a right pleural effusion and pulmonary embolus. For those complications she was treated with antibiotics, a Greenfield filter and oxygen. She responded initially to those treatments but her respiratory function began to deteriorate, and she was transferred to Dartmouth Hitchcock for suspected Adult Respiratory Distress Syndrome (ARDS).

16. At Dartmouth Hitchcock, Patient A was treated for ARDS with ventilatory support and a chest tube for drainage of her empyema. A CT scan of the chest showed fluid around the liver and a follow-up CT scan of her abdomen revealed multiple intra-abdominal abscesses. She required two repeat laparotomies for drainage of the abscesses, irrigation and debridement, ileostomy and placement of a G-tube.

17. Respondent argued that he relied on and trusted his medical consultants who helped to provide care. The Committee finds that the signs of infection and existing problems which were not addressed were *surgical* complications and that the primary responsibility to

suspect, investigate, recognize and treat them lay with the surgeon and not with the medical consultants. Respondent failed to recognize and respond to the existing problems by using available diagnostic procedures, and he failed to properly treat the patient's post-surgical infection.

COUNT 2. PATIENT A

18. This Count alleges that Respondent engaged in unprofessional conduct when, in the care of Patient A, he grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, in violation of 26 V.S.A. § 1354(22) and 3 V.S.A. § 129a(a)(10). Findings 10-17 set forth above pertain to this count.

COUNT 3. PATIENT A

19. This Count alleges unprofessional conduct, defined as conduct which evidences "unfitness to practice medicine" under 26 V.S.A. § 1354(7).

20. The relationship between Respondent and Patient A became increasingly personal beginning in 1997. It eventually included sexual activity. Both Respondent and Patient A agree that the sexual relationship continued over a several year period, 1993 to 2001, during which Respondent also treated Patient A intermittently in a physician-patient capacity.

21. Respondent admits that the sexual relationship concurrent with the physician-patient relationship was wrong and that it violated the *AMA Code of Medical Ethics*. Section 8.14 of the 2000-2001 edition of the Code says, in pertinent part:

> Sexual contact that occurs concurrent with the physician-patient relationship constitutes sexual misconduct.... If a physician has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, a physician's ethical duties include terminating the physician-patient relationship before initiating a dating, romantic, or sexual relationship with a patient.

Respondent's intimate and sexual relationship with Patient A compromised and affected his objectivity with regard to his care of her and exploited knowledge, trust, and emotions that resulted from his care of her.

22. There was an allegation that a single episode of sexual intercourse occurred in Patient A's hospital room while she was admitted to the hospital as Respondent's patient. The Committee finds that the evidence presented does not establish by a preponderance of the evidence that an episode of sexual intercourse between Respondent and Patient A occurred while the patient was a hospital in-patient under Respondent's care.

COUNT 4. PATIENT A

23. This Count alleges that Respondent, by one or more acts related to the care of Patient A, engaged in unprofessional conduct in that he failed to comply with the "Bill of Rights for Hospital Patients", 18 V.S.A. § 1852. Failure to comply with that statute constitutes grounds for unprofessional conduct under 3 V.S.A. § 129a(a)(3) and 26 V.S.A. § 1354(24). Findings 20-22 set forth above pertain to this count.

COUNT 5. PATIENT A

24. This count alleges that by one or more acts related to the care of Patient A, Respondent engaged in immoral, unprofessional and/or dishonorable conduct, in violation of 26 V.S.A. § 1398. Findings 11-17 and 20-22 set forth above pertain to this count.

COUNT 6. PATIENT A

25. This Count alleges misconduct under 3 V.S.A. § 129a(a)(11) related to Respondent's care of Patient A. The pertinent subsection of the statute defines "unprofessional conduct" to include exercising undue influence on or taking improper advantage of a person using professional services in a manner which exploits a person for the financial gain of the practitioner or a third party.

COUNT 7. PATIENT D

26. This count alleges unprofessional conduct under 26 V.S.A. § 1354(22) related to Respondent's care of Patient D. The pertinent subsection of the statute defines "unprofessional conduct" to include a gross failure to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary, skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions.

27. Patient D was a female patient who had surgery to remove a rectal stump that was created when she had a prior colectomy for Crohn's disease and to repair a recto-vaginal fistula. During the surgery no ureteral stents were used. The surgery was difficult because of a large amount of very dense scar tissue. There was no mention in the operative note that the ureters were identified or that any attempt had been made to identify them during the operative procedure, although the report did include the statement that the "ovaries, uterus and fallopian tubes were identified and dissected free of adhesions".

28. Post-operatively, Dr. Mech, a pathologist, examined tissue from the surgery and noted "an interesting structure which... I wasn't sure, but the thought crossed my mind that it might be ureter." He went to Respondent's office and asked him whether he might have injured a ureter. Respondent denied that, saying "I was nowhere near the ureter". Dr. Mech testified that he believed the conversation with Respondent occurred on March 27, 2001. He also testified that he was not sure whether the patient was still in the hospital on that date.

The written pathology report and the addendum pathology report never made a definite identification of the tissue in question as ureter but listed ureter as one of several possibilities.

29. The drains from the operative site drained unusually large amounts of fluid. At one time the fluid was described as "hazy yellow". Notwithstanding this high volume of fluid, and the other factors present, Respondent did nothing to diagnostically investigate the possibility that Patient D's ureter had been severed.

30. After discharge from the hospital the patient noted urine draining from her vagina. She was referred to Fletcher Allen Health Care where she was found to have a transected ureter. She had a nephrostomy tube inserted to drain the kidney and eventually required a nephrectomy and the loss of her kidney.

31. The credible evidence established several procedures that would have detected the damage to the ureter and could have prevented the loss of a kidney. Such procedures are described as: stents in the ureters could be used but are not the standard of care; ureters should be identified in this type of surgery and that fact noted in the operative note; a comparative creatinine determination done on the fluid from the drain and on the urine from the bladder would have indicated that the drainage contained a large amount of urine and that a ureter was probably damaged; and an imaging test could have been done to track urine flow. Respondent failed to use any of these procedures in operating on Patient D.

COUNT 8. PATIENT E

32. This count alleges unprofessional conduct under 26 V.S.A. § 1354(22) related to Respondent's care of Patient E. The pertinent subsection of the statute defines "unprofessional conduct" to include a gross failure to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions.

33. Patient E was a male with a massive scrotal hernia that had been present for 30 years. The approximate size of the hernia was estimated during the hearing as being about the size of a basketball. Patient E signed a consent form agreeing to a "routine hernia" repair. Respondent planned for an "overnight" procedure.

34. Hernia repair involves returning the contents of the hernia, such as bowel, to the abdominal cavity and then repairing the defect in the abdominal wall. When a large amount of bowel has escaped from the abdominal cavity and has been located outside of the abdominal cavity for a long period of time, the size of the abdominal cavity contracts, limiting the amount of room available. This is called "loss of domain", meaning that when an attempt is made to place the entire bowel back into the abdominal cavity, there will not be room for it. As a result of this hernia, Patient E had a significant loss of domain.

35. In spite of the size and chronicity of the hernia, conflicting information from two separate ultrasound studies, and a very difficult physical examination due to the thickening of

the scrotal skin, Respondent attempted surgical repair of the hernia. This surgery presented substantial risk to Patient E, and Respondent failed to properly anticipate and plan for the risk.

36. It was impossible to replace the scrotal contents into the abdominal cavity because of "loss of domain". A partial bowel resection was done to reduce the volume which needed to be replaced into the abdomen, but it was still necessary to effect closure of the abdominal wall by using a large sheet of prosthetic mesh.

37. In addition to the massive, chronic hernia and loss of domain, Patient E had chronic obstructive lung disease from years of smoking. He was described as having a barrel chest which indicated decreased mobility of his chest wall for breathing. He was therefore more dependent on the mobility of his diaphragm in order to breath. When bowel was replaced in his abdomen and the abdomen was closed there was increased pressure on his diaphragm which decreased the mobility of the diaphragm. That loss of mobility combined with his barrel chest compromised his breathing to the point that he had to be on a mechanical respirator.

38. Patient E was transferred to Fletcher Allen Health Care immediately after surgery because of complications, and the fact that Copley Hospital does not have the capacity to maintain a patient on a respirator.

39. On arrival at Fletcher Allen, Patient E was taken to the operating room where dead bowel segments were removed and the remaining bowel was replaced into the scrotal sac. Patient E eventually died of the complications.

40. The elective surgery on Patient E could not be carried out with reasonable safety in light of the patient's history, complicating pulmonary condition, and the massive size of the hernia. Respondent's decision to undertake the surgery, and his planning and preparation for it was reckless and indefensible.

COUNT 9. PATIENT B

41. This Count alleges that Respondent's statements to Patient B during his care of her constituted unprofessional conduct under 26 V.S.A. § 1354(7). The pertinent subsection of the statute defines unprofessional conduct to include conduct which evidences an unfitness to practice medicine.

42. During an office visit concerning a hernia, Respondent asked Patient B what her religion was. After she answered he told her he didn't think that God liked her very well. He said he could repair her hernia but with her history a bolt of lightning could hit the operating table. He said he would repair her hernia so that it would not bother her when she was shoveling coal in Hell.

43. Patient B testified that she only knew Respondent through surgery and office visits and had never discussed religion or Hell with him before. The conversation made her uneasy, and she didn't want him doing the procedure on her.

44. Respondent contends that he was attempting humor because Patient B was depressed. He suggested that she might want to try his religion because his life was "sure pretty good right now". He denied the remark that she might be struck by lightning on the operating table and the remark about fixing the hernia so it would not bother her in Hell. However, when asked what he did say he admitted that he could not recall.

COUNT 10

45. This Count alleges that Respondent's statements to Patient B constituted immoral, unprofessional and/or dishonorable conduct under 26 V.S.A. § 1398 during his care of Patient B. Findings 42-44 set forth above pertain to this count.

COUNT 11

46. This Count alleges that Respondent's statements to Patient B failed to comply with 18 V.S.A. § 1852, the Patient's Bill of Rights, as required by 26 V.S.A § 1354(24) and 3 V.S.A. § 129a(a)(3). Findings 42-44 set forth above pertain to this count.

COUNT 12

47. This Count alleges that Respondent exhibited disruptive and/or inappropriate conduct that was unprofessional conduct which evidenced unfitness to practice medicine under 26 V.S.A. § 1354(7).

48. On a specific occasion, the Respondent made remarks to Juliet Boyce, a female in-patient, comparing women to cats and men to dogs. The remarks included the statement that cats/women walk around in cheap fur coats and make messes and that dogs/men sniff people's crotches. The patient found the remarks offensive.

49. Respondent admitted the conversation about the cat/dog remarks but said that the patient's husband originally told the joke.

50. Respondent also said to the same patient and her husband that in his next life he wanted to be a porn star named "Bolt Upright". The statement was accompanied by a crude hand gesture, starting from the groin and with the thumb held upright. The patient's husband was very upset and angry about the conversation.

51. Respondent admitted the use of the term "Bolt Upright". He testified that the name had been part of a joke among the Operating Room crew. When one of the crew walked by and called him "Bolt", the patient asked why she called him that and he explained the history of it. He denied the crude hand gesture.

52. Gregory McLelland, a person who works in the Copley Hospital emergency department, testified that later Respondent approached him and talked about the cats/women and dogs/men episode. Respondent asked Mr. McLellan to ask a patient if he (Respondent) could talk to her and clear the air about that comment he had made to her earlier. Mr. McLellan asked the patient and her husband if Respondent could talk with them, but they didn't want to speak to Respondent.

COUNT 13

53. This Count alleges that Respondent's statements to Juliet Boyce constituted immoral, unprofessional and/or dishonorable conduct in violation of 26 V.S.A. § 1398. Findings 48-52 set forth above pertain to this count.

COUNT 14

54. This Count alleges that Respondent statements to Juliet Boyce constituted unprofessional conduct in that he failed to comply with the Patient's Bill of Rights, 18 V.S.A. § 1852, as required by 26 V.S.A. § 1354(24) and 3 V.S.A. § 129a(a)(3). Findings 48-52 set forth above pertain to this count.

COUNT 15

55. This Count alleges that Respondent engaged in certain disruptive and/or inappropriate conduct which evidenced unfitness to practice medicine under 26 V.S.A. § 1354(7).

56. On a specific occasion, Respondent reacted angrily when he learned that one of his patients had received an intramuscular injection on the order of another physician. He objected loudly, threw a chart and slammed a door. He returned and pounded on the door and spoke angrily again.

57. Nurse Waters testified that on that occasion Respondent came to the nurses' station and asked why his patient got a shot in the butt? He repeated it several times, and each time it was louder, and he sounded angrier. Respondent picked up the patient's chart and threw it across the room. Respondent turned away from those present and walked out the door and slammed the door loudly. A little later he returned and banged several times on the door glass with both fists. Nurse Waters told the other staff present that if he comes back again, do not open that door. She was frightened of what he might do.

58. Nurse Waters testified that one of the most important roles for a nurse is to be a patient advocate by being the eyes and ears about a patient's condition so they can pass that information on to the patient's physician. The effect of the episode on her was that in the future while caring for any of Dr. Baska's patients, she would have a difficult time calling him to ask questions or to raise concerns.

59. Respondent testified that this was one of several times that nurses had called or talked with another physician about his patients and had received treatment orders from the other

physician who knew little or nothing about the patient. He admitted he was angry because of such acts by nurses. Such acts or errors may be dangerous or harmful to the patient. Respondent argued that his anger was therefore justified. The Committee understands the seriousness of nursing errors and the danger and harm such errors may create. However, disruptive behavior, which nurses testified frightened them, is not an acceptable, effective or professional way to deal with the problem.

60. On a separate occasion, Respondent was called in to assist with an emergency C-section on Mrs. Juskiewicz who had been in labor for 24 to 28 hours. Respondent and Mark Juskiewicz, the husband/father, were changing into scrubs in the dressing room at the same time. Mr. Juskiewicz testified that Respondent said he did not want to be there at 4:00 A.M. Mr. Juskiewicz suggested that was the wrong thing to say to a husband at a time like that. Mr. Juskiewicz felt that Respondent then threatened him by saying that he (Respondent) did not have to deliver the baby. Respondent further stated to the husband that if he was upset with Respondent, that Respondent could leave. Mr. Juskiewicz interpreted that as a threat because if Respondent left and another surgeon had to be called in to assist it would mean that Mr. Juskiewicz's wife would have to wait longer.

COUNT 16

61. This Count alleges that Respondent's actions constituted unprofessional conduct in that they evidenced a failure to comply with 18 V.S.A. § 1852, The Patient's Bill of Rights, as required by 26 V.S.A. § 1354(24) and 3 V.S.A. § 129a(a)(3). Findings 56-60 set forth above pertain to this count.

COUNT 17

62. This Count alleges that Respondent's actions established that he engaged in immoral, unprofessional, and/or dishonorable conduct under 26 V.S.A. § 1398. Findings 56-60 set forth above pertain to this count.

COUNT 18

63. This Count alleges that Respondent engaged in unprofessional conduct in that his conduct evidenced unfitness to practice medicine under 26 V.S.A. § 1354(7).

64. In April 2000 Respondent was called on the telephone by a concerned nurse, Lonny Brashier, because a patient was found to have stool coming from an incision. Respondent did not offer to see the patient, but ordered Nurse Brashier to apply an ostomy bag to the area to protect the skin. Respondent explained the rationale for this procedure. The nurse continued to worry, and eventually consulted another physician. The other physician examined the patient and then personally called Respondent about the problem.

65. Nurse Brashier testified by pre-filed affidavit and by speaker-phone during the hearing. He testified that after having been contacted by the other physician, Respondent came into the intensive care unit. Respondent loudly shouted at Mr Brashier, "You fucking

don't exist here anymore" and "You are a joke to your profession. You are incompetent." Patients and other nurses were present and appeared to hear what Respondent said. The nurse felt humiliated, and was so disturbed that he had trouble concentrating and performing his duties that evening. The testimony describing the episode of verbal attack on Nurse Brashier was clear, credible, and persuasive.

66. Respondent admitted in his testimony that he came in and yelled at the nurse. He admitted that he said a number of things, and he was incorrect in the way he treated him the first time. However, Respondent never apologized to the nurse for his conduct.

67. In another incident in August 2000, at the start of a surgical procedure, Respondent twice threw surgical instruments across the operating room.

COUNT 19

68. This Count alleges that Respondent's actions established that he engaged in immoral, unprofessional, and/or dishonorable conduct under 26 V.S.A. § 1398. Findings 64-67 set forth above pertain to this count.

COUNT 20

69. This Count alleges that Respondent engaged in disruptive and/or inappropriate conduct which evidenced unfitness to practice medicine under 26 V.S.A. § 1354(7).

70. In September 2000 the nursing staff made an error and called another physician regarding a patient of Respondent's who was in a medical crisis. By pre-filed and in-person testimony, Nurse Lynda Reiss said that during the apparent emergent situation, she told another staff member to call Dr. Kozub, whom she mistakenly thought was that patient's attending physician. Dr. Southall, who was covering for Dr. Kozub responded. Nurse Reiss said she believed she committed this error, because she knew that Dr. Kozub had been that patient's attending physician on a prior admission to the hospital.

71. Respondent arrived on the scene while making his usual rounds. Ms. Reiss apologized to him for the mistake regarding who should have been called. Respondent was very angry. Ms. Reiss and the Respondent went to a nearby room to discuss the matter. There, Respondent began swearing and shouting. He slammed a chair on the floor and screamed that his patient was "coding" and that he had been "f---king raped!" Nurse Reiss further testified that Dr. Baska's anger, rage, and behavior were extreme and beyond any reasonable bounds of conduct. His emotional lack of control was frightening and undermined the ability and willingness of Nurse Reiss to work professionally and show initiative. She did not feel safe and could not perform effectively while being traumatized by a doctor's emotional tirades, verbal abuse, and explosions of anger. She had been the target of Respondent's behavior in the past. Ms. Reiss wrote a letter to the hospital administrator about what had happened.

72. Ellen Hagman, who is currently Vice President of Nursing at Copley Hospital, also testified about this incident. She talked with Dr. Baska, at his request, about the nursing error in calling the wrong doctor. She described him as extremely enraged. He was pacing and saying he felt like had been raped, his voice was raised, he smashed a chair on the ground and picked up a toaster and smashed it.

73. Dr. Southall, the physician who was called in error, testified. He testified that he remembered the event "in somewhat embarrassing lack of detail". His testimony was, therefore, not very persuasive.

74. Respondent testified that he felt like he "had been betrayed" when he arrived and found that another doctor had been called instead of him. Respondent heard Ms. Hagman's testimony regarding this incident, and he admitted her testimony was accurate. Respondent also denied that there was any encounter between him and Nurse Reiss on that day. He agreed that "slamming a chair and all of that" happened but that it happened with Ms. Hagman and not with Ms. Reiss. The Committee finds Nurse Reiss to be a credible witness, and that Respondent engaged in the behavior described in her testimony.

COUNT 21

75. This Count alleges that Respondent's behavior was immoral, unprofessional, and /or dishonorable conduct under 26 V.S.A. § 1398. Findings 70-74 as set forth above, apply to this count.

COUNT 22

76. This Count alleges that Respondent threatened to harm Warren West, the hospital administrator, in April 2001, and by doing so engaged in unprofessional conduct which evidenced unfitness to practice medicine under 26 V.S.A. § 1354(7).

77. Janet Lewia, the operating room Nurse Manager at Copley Hospital, testified by pre-filed written testimony and in person. She described herself as having been a "work and social" acquaintance of Respondent. She had also asked Respondent to perform surgery for both her daughter and herself.

78. Nurse Lewia said that when Mr. West refused to let Respondent perform bariatric surgery at the hospital because of lack of an adequate operating room table, Respondent said, "I'm going to kill Warren West. If I had a gun, I'd shoot him." Nurse Lewia then asked, "You don't mean it?" Respondent replied, "Yes, I do, I'm gonna get him." In her verbal testimony Nurse Lewia said, "And we had that repetitive conversation three or four times where he continued to reassure me that if he had a gun, he would shoot the hospital president." Nurse Lewia said that she took the threat to Mr. West seriously, because issues had been discussed within the hospital regarding Dr. Baska's behavior and anger. Examples of the behavior and anger cited were Respondent yelling at nurses and throwing surgical instruments. The Hearing Committee finds Ms. Lewia to be a credible witness and that Respondent made those statements to her.

79. Nurse Lewia reported this incident because it worried her. She was worried because Respondent had a reputation among the hospital staff as being emotionally unpredictable and explosive, and there were incidents where he blew up and yelled at people and threw things when he was angry.

80. Respondent testified that he "very well could have" said that the hospital administrator was after him. He did not recall threatening to kill him or shoot him with a gun. He admits that he said they should "get rid of" him but that he never meant any physical harm, he merely meant "it was going to be him or me at that hospital".

COUNT 23

81. This Count alleges that Respondent, by his behavior, engaged in immoral, unprofessional and/or dishonorable conduct under 26 V.S.A. §1398. Findings 77-80 as set forth above, apply to this count.

COUNTS 24 THROUGH 27

82. These counts appear to be aggregation devices which ask the fact finders to go back through the fact patterns presented in Paragraphs 7 through 34 of the Charges and re-assess whether Respondent:

(a) engaged in unprofessional conduct in that in the course of practice he engaged in conduct that evidenced unfitness to practice medicine under 26 V.S.A. § 1354(7);

(b) engaged in immoral, unprofessional, and/or dishonorable conduct under 26 V.A. § 1398;

(c) engaged in unprofessional conduct in that, in the course of practice, he failed to use and exercise on repeated occasions that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in a similar practice under the same or similar conditions, whether or not actual injury to a patient occurred under 26 V.S.A. § 1354(22) and 3 V.S.A. § 129a(a)(10; and/or

(d) showed conduct which included a gross failure to use and exercise on at least one occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in a similar practice under the same or similar conditions, whether or not actual injury to a patient occurred under 26 V.S.A. § 1354(22) and 3 V.S.A. § 129a(a)(10).

83. This seems unnecessarily repetitive. Those determinations have been made where charged. The Committee sees no reason to re-examine the specific charges.

84. However, the Committee did examine exhibits and hear extensive testimony regarding the care that Respondent provided for Patients B, C, F, and G which were not specifically addressed in Counts 1 through 23. The Committee believes that it has the authority and the obligation to report its analysis of that care, and whether it violates the statutes, under Counts 24 through 27.

COUNT 24

85. This count alleges that Respondent engaged in unprofessional conduct in that in the course of practice he engaged in conduct that evidenced unfitness to practice medicine under 26 V.S.A. § 1354(7).

PATIENT B

86. Patient B was a female patient who, on October 3, 2000, had a sigmoid resection for diverticular disease because of recurrent left lower quadrant pain with bloating. The pain responded temporarily to antibiotic treatment. A Barium enema demonstrated scattered sigmoid diverticula. Abdominal and pelvic CT scans revealed findings consistent with diverticulitis.

87. A sigmoid resection was done on October 3, 2000. Time of the surgery was 56 minutes and estimated blood loss was "minimal to 200cc". Following surgery the patient did not do well.

88. Prior to surgery Patient B's hemoglobin and hematocrit were 16.0 and 46. On the first post-operative day her Hemoglobin and hematocrit were 11.1 and 31. On the second post operative day they were 7.7 and 22. In spite of transfusions, Patient B's hemoglobin stayed in the 9 to10 range and her Hematocrit stayed in the 28 to 30 range.

89. Patient B had a pre-operative white blood count of 13.8. She had a prior history of an elevated WBC, although this was not mentioned in the history and physical done at the time of the surgical admission. Her WBC rose slightly immediately after surgery and then rose significantly on the 4th post-operative day to 25.2. On the 9th and 10th post-operative days her WBCs were 28.2 and 36.4 with a significant bandemia of 69 and 60 %.

90. Dr. Blowers, the surgeon who assisted Respondent with Patient B's surgery, testified concerning the patient's treatment. Although the procedure went very well, the patient, in his opinion, wasn't getting well as fast as he would expect her to. Patient B had prolonged abdominal distention, pain, and some fever, and her bowel function did not return when Dr. Blower's hoped that it would.

91. Dr. Blowers was concerned enough to have a "hallway consultation" with Respondent during which Dr. Blowers asked Respondent if he thought Patient B might have a pelvic abscess. Respondent replied that he did not think she did.

92. Respondent testified that he talked with Patient B about the possible options, and the patient elected to continue with clinical observation, because she was afraid of the enormous cost of a CT scan. The Hearing Committee does not find Respondent credible on this matter.

93. Patient B testified that she just didn't improve but got steadily worse after surgery. She said that Respondent did talk with her about a CT scan but told her that it really wasn't necessary to do because it would check his work, but he didn't make mistakes. Patient B also testified that she "had 100 percent coverage insurance" at the time, and it would have paid for the CT scan. The Hearing Committee finds Patient B to be credible on this matter.

94. Patient B was discharged to "Residential care" on post-operative day 10 despite the unaccounted for blood loss, elevated WBC and band counts, low grade fevers, and prolonged ileus. She remained in "Residential Care" for 3 more days and was then discharged to home. At the time she went home she felt terrible. Her feet were very swollen. She weighed 213 pounds, was full of fluid, and had to be sent home with a walker because she couldn't support the upper half of her body. Patient B's hospital records documented her weight at the time of admission as 188 pounds. The Patient progress notes describe her activity on Day 10 as "... uses walker to ambulate."

95. Respondent testified that the transfer to "Residential Care" was not a discharge but was a bureaucratic transfer within Copley Hospital for 3 more days with essentially the same nursing care but with a different billing system.

96. Two days after discharge from Copley Hospital, apparently on post operative day 13, Patient B was admitted to Fletcher Allen Health Care for treatment of a pelvic abscess.

97. The development of a post-surgical intra-abdominal abscess is a recognized possible complication of the surgery that Respondent performed. Respondent failed to recognize the indications, such as highly elevated white blood count, present in Patient B, and failed to pursue available procedures to determine if infection was present, and failed to treat her complications.

PATIENT C

98. Patient C was a 76 year-old woman who had a sigmoid resection on March 6, 2001 because of a long history of abdominal pain thought to be due to diverticular disease. An endoscopy done by Respondent was interpreted to show "very significant diverticular disease". A CT scan of the pelvis with contrast medium reported that "the recto sigmoid is unremarkable". The post-operative pathology report noted multiple diverticula on the gross examination and "diverticula microscopically without evidence of any inflammatory process".

99. The operation was performed in 45 minutes. A recognized complication of the surgery performed on Patient C, a sigmoid resection, is possible post-operative bleeding. The estimated blood loss during the surgery was 100 cc's.

100. Patient C's pre-operative hemoglobin and hematocrit were 14.8 and 46. On post-op day 1 those values were 8.8 and 28. On post-op day 4 those values were 6.3 and 20. The highest they ever got was on day 8 when they were 10.3 and 33. These values remained low until her death and indicate a very substantial post-operative loss of blood. During the post-op period Patient C had 11 or 12 units of blood or packed red blood cells. In addition to a

possible clotting problem secondary to Coumadin, which Patient C had been taking pre-operatively, blood transfusions themselves contain small amounts of anticoagulant.

101. The nurses reported some frankly bloody stool and sanguineous material with the stools. The amounts reported, up until the final day of her hospitalization, were not enough to account for her low blood count and the need for multiple transfusions. In fact, a progress note written by Respondent on post-op day 4 reads, "if she is bleeding – where?"

102. Patient C had been taking Coumadin, an anticoagulant, prior to surgery because of chronic atrial fibrillation. A note in Respondent's office records said that on February 8, 2001, her clotting profile showed INR= 3.42 and PT = 22.5. Respondent did not order a coagulation study prior to restarting Patient C on Coumadin. A coagulation study would have determined whether she had a normal clotting capacity. The Hearing Committee finds that Respondent's failure to order a coagulation study in these circumstances placed Patient C in unnecessary danger.

103. Admission orders written on March 6, 2001, include an order for "Coumadin 2 mg q PM – start 7 Mar 01". On March 7, 2001, there was an order to "Hold coumadin this PM". On March 11, 2001, an order was written for "Coumadin 2 mg P.O q PM". On March 14, 2001, an order to "Hold Coumadin until further notice" was written. Later that same day clotting studies were ordered for the first time during the hospitalization. The results were reported on March 15, 2001, the day Patient C died, and were PT = 37.7, INR = 10.21 and PTT = 43.9. The lab report noted that the PT and PTT were "high" and the INR was both "high" and "critical".

104. Patient C received fresh frozen plasma and Hetastarch, both of which are given to improve a person's clotting status. However, the need for or effect of those treatments was never checked or monitored with any laboratory tests until the ones done March 15, 2001, the day Patient C died.

105. Dr. Labow, an expert witness for the State, testified concerning Patient C. Despite the fact that she was manifesting all these episodes of bleeding, on the 5th post-operative day she was restarted on her Coumadin without doing any kind of a coagulation profile. He testified that to anticoagulate somebody who's actively bleeding without doing a coagulation profile was something he couldn't comprehend.

106. Dr. Grabowski, an expert witness for the State, expressed concern that the amount of blood lost by Patient C may not have been accounted for by that lost via the rectum. He questioned whether there was both bleeding from the rectum and internal bleeding. He also opined that a "... very acceptable if not essential standard of care would be if the patient wasn't responding to blood transfusions and was continuing to show signs of bleeding, that re-operation would be necessary."

107. Dr. Grabowski summarized the case by saying that the patient bled to death after surgery without any effort made at diagnosing the reason for the bleeding or treating the

patient for it, and no explanation was given as to why that was not done in the record he had available.

108. Dr. Hyman, an expert witness for Respondent, testified that he would be concerned that Patient C required four or five units of blood in the first few days. When asked if it was significant that no PT times were taken, he replied, in part "... certainly because she's had some bleeding, it might be a reason for concern, you know, to make sure it's normal before you check it. I probably would have checked it."

109. On March 14, the notes by both the nurses and Respondent reported blood passed per rectum. The nurses described "frank blood" and "large clots". On March 15 the nurses reported "large amount of clotty frank blood stool" and "large, loose bloody stool".

110. Patient C died on March 15. Respondent's final progress note says this was a "sudden arrest" and that there was "no explanation for arrest but possible respiration".

111. Respondent testified that he had a long conversation with Patient C about the possibility of performing endoscopy, exploratory surgery or imaging studies to look for the source of bleeding. He said that she refused further procedures. There was no progress note documenting such a conversation with Patient C. Respondent testified that he wrote such a progress note but it was missing later. The Hearing Committee does not find Respondent credible on this matter.

112. Rather, Patient C's husband testified that he and his wife were very close and that they discussed everything. He visited her "probably a total of three times a day" and she never mentioned any conversation with Respondent about her continued bleeding and/ or about her refusal to have any more tests or treatment to deal with the bleeding. Respondent did not talk directly with him about the bleeding or the possible choices for dealing with it. The Hearing Committee finds the husband of Patient C to be a credible witness. Respondent had not discussed the bleeding problem or any possible treatment or diagnostic possibilities with either Patient C or her family.

113. Respondent failed to diagnostically investigate the source of Patient C's bleeding. He failed to perform or to document that he even thought of performing any diagnostic tests in order to determine where and why she was bleeding. He failed to check clotting studies post-operatively. He re-started an anticoagulant without re-checking clotting studies and without making any attempt to investigate the reason for the unexplained blood loss and need for multiple transfusions. He failed to consider or investigate the effect of multiple blood transfusions on the patient's ability to clot.

114. Respondent failed to act to halt her bleeding. As the patient bled prior to her death, he failed to act on her behalf. The hearing committee finds no credible explanation for Respondent's failure to act diagnostically to help Patient C.

COUNT 25

115. This Count alleges that Respondent, by his actions, engaged in immoral, unprofessional, and/or dishonorable conduct, in violation of 26 V.S.A. § 1398. The Hearing Committee feels that this count aggregates other counts already addressed. For that reason, the Committee does not reach this count and feels it should be dismissed.

COUNT 26

116. This Count alleges that Respondent failed to use on repeated occasions that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient occurred, in violation of 26 V.S.A. § 1354(22) and 3 V.S.A. § 129A(A)(10). Findings 86-114 as set forth above, apply to this count.

COUNT 27

117. This Count alleges that Respondent demonstrated a gross failure to use and exercise on at least one occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient occurred, under 26 V.S.A. § 1354(22) and 3 V.S.A. § 129a(a)(10). Findings 86-114 as set forth above, apply to this count.

CONCLUSIONS OF LAW

COUNT 1

A. Based on all the evidence, in the care of Patient A, Respondent in the course of practice failed to use and exercise on repeated occasions, that degree of care, skill, and proficiency which is commonly exercised by the ordinary, skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, in violation of 26 V.S.A. § 1354(22) & 3 V.S.A. § 129a(a)(10). The evidence presented showed that Respondent repeatedly, on a day to day basis, failed to investigate the unaccounted for blood loss and failed to investigate why Patient A continued to have a distended abdomen and prolonged ileus.

COUNT 2

B. Based on all the evidence, Respondent's failure to investigate the cause of the significant blood loss and the failure to re-examine the surgical site with at least a CT scan of the abdomen were separate acts that constitute unprofessional conduct in that in the course of practice, he grossly failed on a particular occasion to use and exercise that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and

prudent physician engaged in similar practice under the same or similar conditions, in violation of 26 V.S.A. § 1354 (22) & 3 V.S.A. § 129a(a)(10).

COUNT 3

C. Based on all the evidence, by one or more acts related to the care of Patient A, Respondent engaged in unprofessional conduct in that his conduct evidences unfitness to practice medicine, in violation of 26 V.S.A. § 1354(7).

COUNT 4

D. Based on all the evidence, the State did not show by a preponderance of the evidence that Respondent failed to comply with 18 V.S.A. § 1852 by acts related to the care of Patient A. The Committee feels that there was not sufficient evidence to establish that any violation of the "Bill of Rights for Hospital Patients" as set forth in the applicable statute.

COUNT 5

E. Based on all the evidence, the State did show that Respondent engaged in immoral, unprofessional and/or dishonorable conduct, in violation of 26 V.S.A. § 1398.

COUNT 6

F. The Committee interprets the language in 3 V.S.A. § 129a(a)(11) which reads "exercising undue influence on or taking improper advantage of a person" to include only those behaviors which result in financial gain for the physician by exploitation of the person/patient. For example, encouraging unnecessary surgery, frequent office visits or purchase of medications or appliances directly from the physician would meet the statutory criteria. Based on all the evidence presented, the Committee finds that the State did not show by a preponderance of the evidence that the surgery performed on Patient A was unnecessary or an error. Based on that determination, the Committee finds no unprofessional conduct under 3 V.S.A. § 129a(a)(11).

COUNT 7

G. Based on all of the evidence, Respondent's failure to use even one of the available methods to identify Patient D's ureters or damage to the ureters constitutes unprofessional conduct in that in the course of practice, he grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, in violation of 26 V.S.A. § 1354(22).

COUNT 8

H. Based on all of the evidence, Respondent's decision to perform elective repair of a massive, chronic hernia in a person with significant respiratory disease, especially in a

hospital which had no capacity to provide adequate respiratory support, constitutes unprofessional conduct in that in the course of practice, he grossly failed to use and exercise on a particular occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, in violation of 26 V.S.A. § 1354(22).

COUNT 9

I. Based on all the evidence, the State did not show by a preponderance of the evidence that the Respondent engaged in unprofessional conduct in that his conduct did not evidence unfitness to practice medicine under 26 V.S.A. § 1354(7). Respondent testified that his attempts at humor were "boorish". Respondent's own expert testified that Respondent is "socially naïve" in his attempts at humor. The Committee agrees with those characterizations, but does not feel that the evidence supports a violation as alleged in this Count.

COUNT 10

J. Based on all the evidence, Respondent did engage in immoral, unprofessional and/or dishonorable conduct under 26 V.S.A. § 1398.

COUNT 11

K. Based on all the evidence, the State has not shown by a preponderance of the evidence that Respondent committed unprofessional conduct. There was extremely brief testimony that Respondent showed an indifference to Patient B's outcome and discomfort following surgery. The Committee finds that the evidence presented was not adequate to establish that Respondent acted in violation of 18 V.S.A. § 1852, 26 V.S.A. § 1354(24) and/or 3 V.S.A. § 129a(a)(3).

COUNT 12

L. Based on all the evidence, the State has not shown by a preponderance of the evidence that Respondent has committed unprofessional conduct in that his conduct evidenced unfitness to practice medicine, in violation of 26 V.S.A. § 1354(7). While the remarks were crude and uncalled for, the Committee does not feel the evidence supports a violation as alleged in this Count.

COUNT 13

M. Based on all the evidence, the State has not shown by a preponderance of the evidence that the acts alleged constitute immoral, unprofessional and/or dishonorable conduct under 26 V.S.A. § 1398. The Respondent himself described his behavior and his occasional attempts to use humor in his relationship with patients as "boorish". The Committee agrees with the Respondent's characterization of the acts, but does not feel that the evidences supports a violation as alleged in this Count.

COUNT 14

N. Based on all the evidence, the State did show that the acts found in Findings 48-52, evidences a failure to treat patients with dignity under the Patient's Bill of Rights, 18 V.S.A. § 1852, as required by 26 V.S.A. § 1354(24) and 3 V.S.A. § 129a(a)(3).

COUNT 15

O. Based on all the evidence, the State did show, by a preponderance of the evidence, as found in Findings 55-60, that Respondent was guilty of disruptive and inappropriate conduct which demonstrates an unfitness to practice medicine under 26 V.S.A. § 1354(7).

COUNT 16

P. Based on all the evidence, the State did not show by a preponderance of the evidence that the disruptive and inappropriate behavior alleged, evidences non-compliance with the Patient 's Bill of Rights, 18 V.S.A. § 1852, as required by 26 V.S.A. § 1354(24) and 3 V.S.A. § 129a(a)(1). Although Respondent's behaviors were insensitive, the Committee feels his actions did not violate the statutes cited.

COUNT 17

Q. Based on all the evidence, the State did show, by a preponderance of the evidence, that the disruptive and inappropriate conduct found in Findings 56-60, establishes that Respondent engaged in unprofessional or dishonorable conduct, in violation of 26 V.S.A. § 1398.

COUNT 18

R. Based upon all the evidence, the State did show, by a preponderance of the evidence, that Respondent's actions found in Findings 63-67, constituted unprofessional conduct which evidenced unfitness to practice medicine under 26 V.S.A. § 1354(7).

COUNT 19

S. Based on all the evidence, the State did show, by a preponderance of the evidence, that Respondent's behavior as found in Findings 64-67, constitutes immoral, unprofessional and/or dishonorable conduct under 26 V.S.A. § 1398.

COUNT 20

T. Based on all the evidence, the State has not shown, by a preponderance of the evidence, that Respondent's alleged behavior constituted unprofessional conduct which evidenced unfitness to practice medicine under 26 V.S.A. § 1354(7).

COUNT 21

U. Based on all the evidence presented, the State has shown by a preponderance of the evidence as found in Findings 70-74, that Respondent engaged in immoral, unprofessional and/or dishonorable conduct in violation of 26 V.S.A. § 1398.

COUNT 22

V. Based on all the evidence, the State has not shown by a preponderance of the evidence, that Respondent was guilty of conduct evidencing unfitness to practice medicine under 26 V.S.A. § 1354(7).

COUNT 23

W. Based on all the evidence, the State has shown, by a preponderance of the evidence, that Respondent, as found in Findings 77-80, engaged in immoral, unprofessional and/or dishonorable conduct under 26 V.S.A. § 1398.

COUNT 24

X. Based on all the evidence, the State has shown, by a preponderance of the evidence that the care provided by Respondent to Patient B and Patient C as found in Findings 85-114, constitutes unprofessional conduct in that in the course of practice he engaged in conduct that evidenced unfitness to practice medicine under 26 V.S.A. § 1354(7).

COUNT 25

Y. The Committee concludes that this count aggregates other counts already addressed, and for that reason, it should be dismissed.

COUNT 26

Z. Based on all the evidence, the State has shown by a preponderance of the evidence that, in the care of Patient B and Patient C, as found in Findings 86-114, Respondent repeatedly and day-to-day failed to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful and prudent physician engaged in a similar practice under the same or similar conditions, in violation of 26 V.S.A. § 1354(22) and 3 V.S.A. § 129a(a)(10).

COUNT 27

AA. Based on all the evidence, the State did show by a preponderance of the evidence that Respondent's care of Patient B and Patient C, as found in Findings 86-114 constituted a gross failure to use and exercise on at least one occasion that degree of care, skill and proficiency which is commonly exercised by the ordinary, skillful, careful and prudent physician engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient occurred, under 26 V.S.A. § 1354(22) and 3 V.S.A. § 129a(a)(10).

OPINION

STANDARD OF CARE

In determinations whether or not conduct has violated the statutory standard of care, the Vermont Supreme Court has stated:

> As we noted in Braun, such determinations require applying the facts to a standard of reasonableness and, thus, we defer to the factfinder's determination of whether behavior rises to the level of violating the standard of care and constitutes misconduct."

Lynch v. Office of Professional Regulation, Docket No. 1999-389, (Entry Order, 12/5/01).

The standard of care governing a medical professional, the Court has noted, is a determination to be made within the expertise of the profession, and that profession may apply its own expertise in evaluating evidence regarding whether a professional has violated the standard of care. Lynch, supra, citing Braun v. Board of Dental Examiners, 167 Vt. 110 (1997).

"PEER REVIEW COMMITTEE" EVIDENCE

Prior to the hearing, the State had filed a Motion to Conduct Proceedings Pursuant to Protective Statutory Provisions dated January 25, 2002. The motion requested that the Committee conduct all proceedings related to the disciplinary action in this matter consistent with the statutory provisions set forth in 3 V.S.A. § 131(c); 26 V.S.A. § 1360(c); and 26 V.S.A. § 1443(c). Respondent had no objection to the motion, and the Committee granted the motion. The Committee ordered: (1) the identity and the medical records of the victim of the alleged sexual conduct are confidential pursuant to 26 V.S.A. § 1360(c) and are not subject to public disclosure; (2) the proceedings, reports, records, supporting information, and evidence of any peer review committee provided to the Board under statutory requirement shall not be subject to public disclosure pursuant to 26 V.S.A. § 1443(c); and the Board shall take necessary measures during these proceedings to protect such confidentiality.

During the course of the hearing, State's Exhibits 11, 13, 14, and 21 were determined to be reports or records of a "peer review committee" as referred to in 26 V.S.A. §§ 1441 and

1443. This material, under 26 V.S.A. § 1443(c), "may be used by the board for disciplinary purposes but shall not be subject to public disclosure." Under this statutory mandate, those exhibits were admitted as evidence to be used for disciplinary purposes, but were sealed and will not be disclosed to the public.

In addition, certain witnesses testified at the hearing concerning matters determined to be supporting information and testimonial evidence of a "peer review committee." For the same reasons as stated above, the testimony of those witnesses was admitted into evidence during executive session pursuant to 1 V.S.A. § 313 to be used for disciplinary purposes, but the transcripts of that testimony were recorded under separate cover, sealed, and will not be disclosed to the public.

VOID-FOR-VAGUENESS

Respondent contends that certain provisions under which he is charged are void because of their vagueness. He specifically addresses 26 V.S.A. § 1354(7) and 26 V.S.A. § 1398. In order for a statute to comply with this constitutional standard, it does not have to detail each and every act that is prohibited. It is constitutionally sufficient if the language conveys a definite warning as to what conduct is unlawful when measured by common understanding and practices. Brody v. Barasch, 155 Vt. 103 (1990). In Brody, the Court in reviewing a Psychology Board statute, found that even though the term "moral unfitness" is undefined, it was not unconstitutionally vague. Brody, supra.

> Thus, any board or body whose duty it is to pass upon the qualifications of licensees of the various professions – law, medicine, psychology, or others – must do so by applying some broad and necessarily general standards.

Brody, supra, at 111.

Other jurisdictions have similarly viewed professional regulation statutes. In addressing whether a physician's actions indicated unfitness to practice medicine, the Supreme Court of Washington reasoned:

> In the context of medical disciplinary proceedings, and in the light of the purposes of such proceedings, conduct may indicate unfitness to practice medicine if it raises reasonable concerns that the individual may abuse the status of being a physician in such a way as to harm members of the public, or if it lowers the standing of the medical profession in the public's eyes.

Haley v. The Medical Disciplinary Board, 117 Wash.2d 720, 733, 818 P.2d 1062, 1069 (1991).

Considering the standard that has been applied by the Vermont Supreme Court, the statutes at issue are constitutionally sound.

ABROGATION OF LEGISLATIVE AUTHORITY

Respondent contends that the standard contained in 26 V.S.A. § 1398 is an abrogation of legislative authority and a reliance on unarticulated standards. This appears to be identical to his void-for-vagueness claim, and is similarly rejected based on the authority stated in the above section.

The Hearing Committee respectfully submits this Report to the Board pursuant to 26 V.S.A. § 1355.

THE HEARING COMMITTEE:

Elizabeth A. Turner, M.D., J.D., Chair — July 3, 2002 Date

Katherine M. Ready, Public Member — July 3 2002 Date

FILED WITH THE BOARD: JULY 3, 2002 Date